Pediatrics West, P.C.
health care for the growing years

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices. Should I want to review a more complete description of the uses and disclosures of my health information, I understand that detailed Notice of Privacy Practices will be provided for me upon request. I understand this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Today's Date _____

Patient's Name _____

Date of Birth _____

Primary Care Physician _____

Signature (parent/guardian) _____

Printed Name _____

Relationship to Patient _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ *Initials:* _____ *Reason:* _____ __

Revised 9.2023